Anxiety disorders

see also p 239, 257

Ms M is a 60-year-old widowed Chinese woman with a 6-month history of episodic chest tightness, shortness of breath, pain that "moves all over my body," and numbness in her legs. These attacks, which occur once or twice weekly, occur suddenly, reaching peak intensity within a few minutes. During an attack, pain travels from her chest to her abdomen, groin, and legs. The pain is often accompanied by a sensation of intermittent "hot *Qi*" (air) coming from her abdomen to her throat, making her believe that she is being choked. She also describes feeling as if she is in a closed room or small space.

Ms M is anxious and frustrated about her symptoms and thinks she might have a serious medical problem. She has had frequent medical evaluations by her primary care physician and second opinions from various specialists. Ms M consulted a doctor of traditional Chinese medicine and tried some herbal medications, but has had no relief. She has refused to see a psychiatrist.

ANXIETY DISORDERS IN THE PRIMARY CARE SETTING

Anxiety disorders are a group of mental disturbances characterized by anxiety as a core symptom. In this article, we discuss anxiety disorders common to primary care, specifically panic disorder, generalized anxiety disorder (GAD), and posttraumatic stress disorder (PTSD).

DIAGNOSIS

The diagnosis is made when the constellation of symptoms are consistent with the diagnostic criteria for each disease listed in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)* (see Table linked to this article on our web site). When symptoms of anxiety become pervasive, have signs and symptoms consistent with DSM-IV criteria, and affect the patient's ability to function, the presumed diagnosis is an anxiety disorder.

Which organic illnesses can cause anxiety symptoms?

Some of the disease states associated with prominent anxiety are shown in box 1. These diseases, however, are rare explanations for anxiety and anxiety disorders. Clinical investigations to identify a particular disease entity should only be undertaken if the pre-test probability of the disease is high.

What features are suggestive of an organic cause of anxiety?

An organic cause of anxiety should be suspected when the onset of symptoms is sudden, changes have recently occurred in the patient's medication, or the patient has specific signs and symptoms suggestive of a new organic disease process.

When a patient presents with anxiety, the following features should prompt clinicians to suspect an underlying nonpsychiatric disorder is the cause [1]:

Summary points

- Careful evaluation of an anxious patient will help to determine if the cause of the anxiety is organic or psychological
- Use of herbal and over-the-counter substances should be determined because some herbal products (eg, ginseng, *ma huang*, and certain cough medicines) contain stimulants that cause symptoms of anxiety
- Anxiety is often associated with one or more other mood disorders that may require management and treatment
- Primary care practitioners should incorporate psychological techniques in their medical management of Asian patients with anxiety

Box 1 Disease states associated with anxiety

- Hypo- or hyperthyroidism
- Vestibular dysfunction
- Congestive heart failure
- Cardiac arrhythmia
- Chronic obstructive pulmonary disease
- Pneumonia
- Hyperventilation
- Vitamin B_{12} deficiency
- Porphyria
- Neoplasms
- Encephalitis
- Pulmonary embolism
- Pheochromocytoma
- Hyperadrenalism

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- Onset of anxiety symptoms after the age of 35
- Lack of personal or family history of an anxiety disorder
- Lack of childhood history of significant anxiety, phobias, or separation anxiety
- Absence of significant life events generating or exacerbating the anxiety symptoms
- Lack of avoidance behavior
- Poor response to anxiolytic agents

How do you evaluate an anxious patient?

The medical evaluation of anxious patients should include a complete history and physical examination. Features of the history that merit special attention are:

- Substance use/abuse (eg, caffeine, amphetamines, marijuana, cocaine) and withdrawal (eg, from alcohol or sedative-hypnotics)—both of these can cause anxiety symptoms
- Use of medications with anxiogenic effects (β-adrenergic agonists, theophylline, corticosteroids, thyroid hormone, sympathomimetics, psychostimulants)

Asking Asian patients if they are using any herbs or medicines given by friends or relatives is important because some may contain *ma huang* (a stimulant) or ginseng. These substances may cause or exacerbate anxiety (see below).

Laboratory and medical tests should be performed only as indicated by symptom constellation and clinical judgment.

Which cultural issues are important to consider?

Issues that are important in diagnosing anxiety include the following :

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Dwarf ginseng (*Panax trifolius* L.). The physiologic effects of ginseng may trigger or worsen anxiety

- Many Asian patients do not use the word anxiety. Instead, they discuss "nervousness," "tension," or "being tense"
- Because being anxious is viewed as being weak or incompetent, many Asian patients with anxiety disorders tend to present with physical complaints. A physical problem often is seen as a more legitimate reason to get help and to gain sympathy and support from family members and friends
- Many patients with anxiety disorders also have depression. As many as 50% of patients with anxiety will have an episode of major depression at some time in their life[2]
- Often patients may understand their symptoms as a defined illness that is known only to the specific native culture. Examples include neurasthenia (a "nerve weakness," see p 257), *pa-leng* (Chinese for "fear of cold"), *hwa byung* (Korean for "fire illness") and *taijin kyofusho* (Japanese for "fear of losing face and facing situations)
- Psychosocial issues encountered by new immigrants can exacerbate or create new anxiety
- Some Chinese pharmaceuticals can cause or worsen anxiety. *Ma-huang* contains ephedrine, a common ingredient in cold medication or diet pills, which increases heart rate, blood pressure, and sweating, all markers of anxiety. Ginseng possibly increases the basal metabolic rate and increases heart rate, which may trigger anxiety

TREATMENT

Treating anxiety with medication may be consistent with an Asian patient's view that anxiety is a medical issue rather than a psychological one. In addition, adherence to a medical regimen hinges less on a good language match between patient and physician than would be the case with a psychological treatment program. Medication also has the benefit of relieving distressing physical symptoms and rapidly returning patients to pre-existing functional levels.

A major limitation of treating anxiety with medication alone is that patients do not evaluate their conditioned patterns, coping strategies, or environmental circumstances, which may be the root cause of their anxiety disorder. Failing to address these issues increases the risk of relapse when medication is discontinued.

Therefore, clinicians in primary care settings should emphasize psychological treatments with the same conviction as medical ones. Research findings show that psychopharmacologic[3,4] and cognitive behavioral psychotherapeutic[5-7] interventions individually are effective in the treatment of approximately 60 to 90% of patients with various forms of anxiety disorders. The combination of

medication and psychotherapy produces the most effective long-term results.[8-10]

SPECIFIC DISORDERS

Panic disorder

Clinical assessment

We have found that some Asian patients present with panic attacks that have strong cultural overtones, characterized by only one or two predominant classic symptoms. Our Chinese American patients with anxiety commonly complain of "hot and cold" symptoms (such as *pa-leng*). Despite a consistent environment, they describe sensations of hot or cold *Qi* (air) going up and down their body, along with other bodily discomforts.

"*Hwa byung*" is also a common cultural idiom of distress seen in Korean patients.[11] Lin and colleagues describe this syndrome as highly somatized with anxiety, insomnia, sensations of heat in the body and the impulse to "get out of the house."[11] Patients with these symptoms often recognize that the symptoms are psychological and result from suppressing anger.

Obtaining a brief history of the patient's experience with panic attacks is useful because panic attacks and agoraphobia (fear of being placed in situations where obtaining help is difficult, such as lonely open spaces or traveling alone) may seriously limit the patient's ability to travel to appointments and comply with aftercare. If panic disorder with or without agoraphobia is diagnosed in Asian patients, time may be required to assess patients' travel patterns and their ability to travel beyond their immediate community.

Psychological treatments

Psychological treatments for panic have proven effective both independently and as an adjunct to medication. In a recent randomized controlled trial, investigators compared the effectiveness of cognitive-behavioral therapy, imipramine, or their combination, against placebo in the treatment of panic disorder.[12] Each treatment individually was better than placebo, and the combination treatment was more effective than individual treatments at preventing relapse.

Cognitive-behavioral therapy is the psychological treatment of choice for panic disorder. A protocol developed by Barlow and Craske, which involves exposure, cognitive restructuring, breathing retraining, and relaxation training (box 2), has been well-validated.[13] We have found these treatments are effective in Asian American patients, yet their use may be limited by a lack of bilingual therapists.

Suggestions for practitioners

- Provide a medical explanation that gives patients an understanding of their physical symptoms. Acknowledge that the symptoms are physical but are not related to a serious medical condition, such as heart disease
- Instruct the patient on how to use abdominal breathing (breathing retraining) at the first sign of hyperventilation, anxiety, or a panic attack

Box 2 Psychological therapies for panic disorder

Exposure therapy

- Panic disorder patients are sensitive to internal cues of anxiety and are often afraid of panic attacks recurring
- Exposure therapy aims to weaken the associations between bodily cues and panic reactions
- Exposure is conducted by inducing bodily cues of panic attacks through cardiovascular exercise (increased heart rate), spinning in a chair (dizziness), and hyperventilation (breathing difficulties)
- Cues are repeatedly induced until habituation occurs, and the person learns that these body sensations are normal and that they will not always lead to a panic attack
- Patients who have panic disorder with agoraphobia can be treated with "situational exposure," involving repeated exposure to objects or situations that they avoid (eg, crowded malls)

Cognitive restructuring

- Individuals with panic disorder often hold irrational beliefs, eg, "if I avoid the situation in which I previously had a panic attack, the attack will not occur again"
- The therapist's approach is to restructure the thought process and to teach the client to appraise body sensations more accurately and manage the physical symptoms of anxiety

Breathing retraining

- The therapist teaches the patient proper breathing techniques
- Patients learn to take slow deep breaths and are encouraged to perform abdominal (diaphragmatic) breathing instead of their usual rapid, shallow breathing
- Retraining is important because many patients with panic disorder describe hyperventilatory symptoms as being similar to panic attack symptoms

Relaxation training

- A commonly used and effective technique is progressive muscle relaxation training
- The client learns to relax by progressively tensing and relaxing major muscle groups
- Other useful relaxation techniques include meditation, relaxation tapes, positive visualization, and positive mental imaging
- *tai chi* and *chi gong* may be helpful and culturally familiar meditation techniques for Asian patients

Difficulty concentrating and muscle tension are common signs of generalized anxiety disorder

- Suggest that the patient use relaxation techniques
- Encourage the patient to practice breathing retraining and relaxation techniques during non-panic anxiety states
- Provide helpful literature and/or relaxation tapes that reinforce relaxation techniques

Generalized anxiety disorder (GAD)

Clinical assessment

Generalized anxiety disorder is defined as excessive anxiety or worry in the absence of, or out of proportion to, situational factors. The symptoms of this disorder are restlessness or feeling on edge, being easily fatigued, difficulty concentrating or the patient's mind going blank, irritability, muscle tension, and sleep disturbance. The diagnosis requires that symptoms have been present for more than 6 months.[14]

Pharmacotherapy

The treatment of GAD is similar to treatment for all other anxiety disorders. A selective serotonin reuptake inhibitor (SSRI) may be administered at low doses and adjusted upward for a full therapeutic response.[4] Psychotherapy for patients with GAD has not been well studied.

Posttraumatic stress disorder (PTSD)

Clinical assessment

Posttraumatic stress disorder occurs after exposure to an event involving death, serious injury, or a threat to the physical integrity of self or others. Patients with the condition persistently re-experience the event, such as through dreams and flashbacks; show persistent avoidance behavior, such as diminished involvement in usual activities or relationships; and persistent symptoms of increased arousal, such as irritability and hypervigilance.[14] Events that trigger the disorder include war; torture; natural disaster; violence to self or others, including rape; serious illness; surgery; and events that have an idiosyncratic impact on a given patient.

Immigrants from the Pacific Rim may be at a higher risk of having been exposed to traumatic events related to their journey to the United States or to their reasons for wanting to leave their home country. For example, some immigrants from China have been tortured for political reasons or suffered from enforcement of birth control policy resulting in forced terminations of pregnancies. The prevalence of PTSD is high among Southeast Asian refugees.[15]

Posttraumatic stress disorder is often associated with depression, other anxiety disorders, and substance abuse. Clinicians should assess for these other conditions in patients with PTSD because substance abuse and depression increase suicidal risk. The National Women's Study found that 31% of women who are raped develop PTSD and that 13% of rape victims make a suicide attempt.[16]

Therapy

The treatment of choice for PTSD is SSRI medication and cognitive behavioral psychotherapy, along with therapy for any associated psychiatric illness, such as depression.

Suggestions for practitioners

- If you suspect that a patient has PTSD, assess for substance abuse. If patients are abusing or misusing substances, you should explain what resources are available to help them and discuss the particular risks

of using drugs that may cause dependence, such as short-acting benzodiazepines

- Encourage patients to use relaxation techniques
- Explain that the physical symptoms they experience are common to many people who have experienced a traumatic event. One statement might be: "Sometimes symptoms such as chronic fatigue, headaches, and stomach aches are the body's communication for posttraumatic stress"
- Identify feelings such as fear, anger, guilt, and helplessness, which might help to alleviate the patient's physical symptoms

When Ms M experienced an attack of severe pain in the office of her primary care practitioner, her physician contacted a psychiatrist for an immediate consultation. The psychiatrist rendered the diagnosis of panic disorder and recommended a treatment regimen involving an antidepressant agent, a benzodiazepine, and biweekly supportive and cognitive therapy. After 3 months of therapy, Ms M no longer had symptoms.

The dosage of the benzodiazepine was tapered and she continued to be well for another 6 months while taking the antidepressant alone. Believing that she was cured, Ms M then discontinued the use of the antidepressant against the advice of her psychiatrist. Two months later, her symptoms recurred and she resumed taking the antidepressant.

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